

PERE GABARRÓ I GARCIA

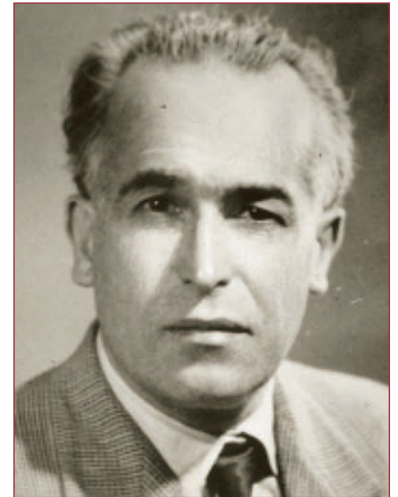
GABARRÓ EPONYMS

The eponyms

Gabarró chessboard grafts. Lamellar grafts cut into small squares from a large piece and placed with a small separation between them to cover a greater surface area of skin, thereby allowing the exudate produced to flow. They are also called postage-stamp grafts, Gabarró checkerboard grafts, and Gabarró postage-stamp grafts^{1,2}.

Gabarró graft board. A plate with squares that enables skin grafts to be cut accurately to a definite width. It is also known as the Gabarró board³.

Gabarró dermatome. A specific type of dermatome (an instrument for cutting lamellar skin segments, employed in graft surgery) that obtains very thin and small laminates, with highly satisfactory results¹.



Pere Gabarró
i Garcia (1899-1980)

Pere Gabarró i Garcia (1899-1980)

Pere Gabarró i Garcia was born in Igualada on 1 January 1899. He was the youngest of twelve children of the marriage between Aleix Gabarró i Castelló and Teresa Garcia i Fossas⁴.

He studied at the *Universitat de Barcelona*, where he received degrees in pharmacy in 1918 (“my family wanted me to become a pharmacist”) and medicine (“I wanted to be a surgeon”) in 1924. Later, he moved to Madrid to do his doctorate⁵. He married Josefina Viader in 1928, and they had two daughters and a son⁴.

He began his professional activity as a physician in 1924, establishing his consultancy in Barcelona. He completed his training at the Faculty of Medicine and was an assistant professor, teaching the laboratory classes of Legal Medicine and Toxicology (1923-1925), Topographical Anatomy and Operations (1929-1930), and Surgical Pathology I and II (1930-1933)^{2,4,6,7}. From 1924 to 1939 he was also a member of Professor Joaquim Trias i Pujol’s Clinic of Surgical Therapeutics⁵. He broadened his studies in digestive semiology at the *Hospital de la Santa Creu i Sant Pau* with Francesc Gallart (1929). For several years he also was a member of Joan Puig-Sureda’s team, working as his assistant, above all in abdominal surgery. Following his teachers, he first specialised in general surgery, particularly in abdominal surgery⁴. In 1933, he also worked as a surgeon at *Institut Policlínic - Clínica Plató* in Barcelona⁷.

He was a pioneer in plastic surgery in Catalonia and Spain⁷, beginning to work in this specialty in 1930. Initially self-taught, his training entailed studying the works of Marion, Joseph, and Gillies⁴. In 1933, he presented the first important study in this specialisation at the *Societat de Cirurgia de Catalunya* of which he was the secretary^{2,4,7}. It detailed the facial reconstruction of a miner who had been disfigured in an explosion,

losing his eyes, part of his nose, and one cheek (*Una plàstia important de la cara* - Substantial plastic surgery on the face)⁸. The same year the government of Catalonia's nursing school was founded, and Gabarró became one of its teachers⁴.

During the Spanish Civil War, he continued working as a surgeon, joining the ranks of the Republican Army. The characteristics of the injuries he dealt with in that dramatic situation aided his practice as a plastic surgeon, an area in which he gained extensive experience. During the war, he was a representative for *Acció Catalana Republicana* (a Catalan political party) on the Catalan government's *Consell de Sanitat de Guerra*⁹, and was later designated an army commander and head of the surgical team. During the years of conflict, he organised the treatment of burn victims on the Republican side in Catalonia and Valencia⁵. He was sent to the Aragon front (to Codo, Puebla de Híjar and Barbastro); from 1938 he was assigned to different Catalan hospitals, ranging from Gandesa in the south to Santa Coloma de Farners in the north, and finally to the hospital train, which on 5 February 1939, would carry him into exile⁴.

Closely identified with the Catalan cause, he was undersecretary at the *IX Congrés de Metges i Biòlegs de Llengua Catalana* held in Perpignan in 1936^{2,5,7}. He formed part of the Editorial Board of the journal *La Medicina Catalana* (Catalan Medicine), of which Leandre Cervera was editor-in-chief. Gabarró was editor-in-chief of the *Butlletí de la Societat de Cirurgia de Catalunya* (Bulletin of the Society of Surgery of Catalonia) when in 1931, the names of the journal and of the society (until then *Sociedad de Cirugía de Barcelona* – Society of Surgery of Barcelona) was changed. Gabarró was instrumental in changing the language of this journal from Spanish to Catalan¹⁰. He was the secretary of this society and, as such, delivered the speech *En defensa de l'ús exclusiu del català en totes les publicacions de la Societat de Cirurgia de Catalunya* (In defense of the exclusive use of Catalan in all publications of the Society of Surgery of Catalonia)^{2,11,12}. After delivering this speech

he managed, after a fierce debate, to have Catalan declared the Society's sole language.

He was secretary of the *Comitè de Recerques i Investigacions Històriques de l'Associació de Metges i Biòlegs de Llengua Catalana* promoting the study of the history of Catalan surgery. He participated in the X International Congress on the History of Medicine in Madrid in 1935^{4,6} and in the commemoration of the birth of Antoni de Gimbernat at the *VIIIè Congrès de Metges i Biòlegs de Llengua Catalana* (VIII Congress of Catalan Language Physicians and Biologists) (1934)¹³, promoting the creation of a prize for the best studies on the history of Catalan surgery^{4,11}.

He was also a member of the *Sindicat de Metges de Catalunya* a professional organization), the *Acadèmia de Ciències Mèdiques de Catalunya*, the *Societat de Cirurgia de Catalunya* and the Congresses of Catalan Language Physicians and Biologists. He also collaborated on the *Diccionari de Medicina* (Catalan Dictionary of Medicine) edited by Manuel Corachán⁴ (see the chapter on Manuel Corachán in this volume).

A Catalan nationalist, his ideas caused more than a few problems¹⁴. As early as 1922, he was arrested for participating in a "Pro-Catalan Rights" political meeting¹⁵. In 1939, he went into exile. He travelled first to France and 15 days later to England, settling first in London and finally in Manchester^{2,4,6,7,16,17}. There, he entered Sir Harold Gillies's school, where he worked for several years (thanks to his skill as a draftsman he was able to enrol without having to pay; in exchange, he drew Sir Harold's operating diagrams). He also worked and trained under Archibald McIndoe, head surgeon of the Royal Air Force. During that period, he learned how they treated aviation burn victims during the Second World War^{2,7,17}.

Portrait of Pere Gabarró, surgeon
in the Republican Army during the
Spanish Civil War



In autumn 1942, he obtained a place in EMS Maxillofacial Unit 18 at Baguley Emergency Hospital while also working at the Christie Cancer Hospital and Holt Radium Institute and at the Duchess of York Hospital for Babies^{2,4,6,7,14,19}. At Baguley, he began as a junior surgeon, becoming an assistant surgeon six months later and senior surgeon a year after that. So he acquired wide-ranging experience in treating patients with injuries caused by cancer, burn victims, and wounded combatants. That was when he developed a new type of tissue graft in a chessboard or postage-stamp format, and a plate that enabled the width of grafts to be set, both of which bear his name.

One of the founders of the *Moviment Escolta* (similar to the scout movement) in Catalonia, he was a keen hiker. He was a member of the *Centre Excursionista de Catalunya* and published medical articles for hikers. He also gave many conferences on medical subjects related to

hiking (e.g., “How to help an injured person in the mountains”, at the *Centre Excursionista de Catalunya* in 1933)²⁰. He described “Via Gabarró”, a new route to climb the Pica d’Estats^{4,6,7} (a three-peaked mountain in the Montcalm Massif in the Pyrenees, on the Spanish–French border; the highest in Catalonia). In his honour, the 3,115-meter Eastern peak, situated between Alins and Ariège, is called “Punta de Gabarró”²¹.

He also had other hobbies: he played the piano beautifully¹⁹ and was a keen cyclist. Furthermore, as noted above, he was a talented artist, drawing the procedures and techniques he employed in surgery himself¹⁴. Many of the illustrations included in Gillies’ *The Principles and Art of Plastic Surgery* are his work¹⁹.

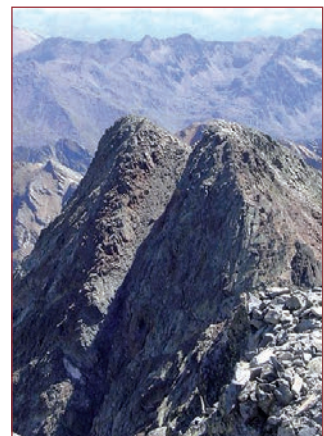
A member of several entities, he was a founding member of the British Association of Plastic Surgeons (1946)^{5,7,16} and was the American Society of Plastic and Reconstructive Surgery’s delegate in Spain (1950-1952)⁵. He was also one of the founders of the *Casal Català* of London²².

He wrote many works on broad-ranging subjects, highlights of which include: *Pel país dels fjords. Viatge per Noruega* (Through the country of



Left: Pere Gabarró (standing with glasses on the left of the photograph) and his hiking partners in Mont Perdut (Lost Mountain) in the Pyrenees

Right: Punta de Gabarró (3,115 m), a mountain in the Montcalm Massif in the Pyrenees, between municipalities of Arins (Catalonia) and Ariège (France)



fjords: Journey to Norway, 1930), *Com cal auxiliar un ferit* (How to help a wounded person, 1930 and 1934), *Les publicacions científiques i la llengua catalana. En defensa de l'ús exclusiu del català en totes les publicacions de la Societat de Cirurgia de Catalunya* (Scientific publications and Catalan: In defence of the exclusive use of Catalan in all publications of the Society of Surgery of Catalonia, 1933), *La cirugía plástica y estética y la cirugía general* (Plastic and aesthetic surgery and general surgery, 1947), *La cirugía plástica en el tratamiento de los cánceres faciales* (Plastic surgery in the treatment of facial cancers, 1955), *Estado actual de la cirugía plástica* (Current state of plastic surgery, 1955), and *Visió gràfica dels Pirineus de Lleida* (Graphic view of the Lleida Pyrenees, 1973).

He also published numerous articles in scientific journals, including *Actas Dermo-sifiliográficas*, *Anales de Medicina y Cirugía*, *Anales de Medicina*, *Archivos Médico-Quirúrgicos y del Trabajo*, *Barcelona Quirúrgica*, *Butlletí de la Societat de Cirurgia de Catalunya*, *Treballs de la Societat Catalana de Biologia*, *Revista de Cirugía*, and *Revista de Sanidad Militar*, among others of international renown, such as *British Journal of Plastic Surgery*, *British Medical Journal*, *Surgery, Plastic and Reconstructive Surgery*, *Proceedings of the Royal Society of Medicine*, and *The Lancet*.

He returned to Barcelona in March 1947 to rejoin his wife, his children, and his mother. Since he was not reinstated in the positions he had attained by official exam before his exile, he began to work with Xavier Vilanova. Later on, he began to work at *Hospital de la Santa Creu i de Sant Pau*, with Joan Puig-Sureda (1947) and later with Jaume Pi i Figueres (1950). At this hospital he created the Plastic and Reparative Surgery Unit, the first of its kind in Spain^{2,4,5,7,16}. He also worked at the *Institut and Clínica Corachán* where he was the director of the Department of Plastic and Facial Surgery. He established his professional office on Diagonal Avenue in Barcelona^{7,16}.

In 1953, he organised the I Course in Plastic and Reconstructive Surgery at *Hospital de la Santa Creu i Sant Pau* at a time when plastic surgery had

little recognition as a specialty. He would organise seven more through 1959⁴.

In 1956, Vicente Mirabet Ippòlito invited him to form, alongside other Spanish specialists, the core of the *Sociedad Española de Cirugía Plástica* which held its first congress in 1959².

Gabarró is considered the pioneer of plastic surgery in Barcelona. He was a founding member and the first president (1961-1965) of the *Societat Catalana de Cirurgia Plàstica* of the *Acadèmia de Ciències Mèdiques de Catalunya* the point from which plastic surgery is considered consolidated as a specialisation in Catalonia². Gabarró also collaborated with the *Societat Catalana de Biologia* from 1962.

Gabarró never received any support or consideration from the Spanish medical establishment during Franco's dictatorship even though he was an internationally renowned figure in plastic surgery and often invited to give conferences and participate in congresses, courses, and homages^{4,5}.

He died in Barcelona on 4 May 1980, after a few laps in the pool at a swimming club in Barcelona⁵.

For several years, the *Societat Catalana de Cirurgia Plàstica* has awarded a Pere Gabarró i Garcia Scholarship and the City Council of Igualada, together with the Anoia Subsidiary of the *Acadèmia*, awards the Pere Gabarró Health Research Prize. The *Col·legi Oficial de Metges de Barcelona* declared 2009 "Dr Pere Gabarró Year"^{4,5}.

Gabarró eponyms

Gabarró's scientific activity was highly important and he made several contributions to plastic surgery. Especially important was a new method



Pere Gabarró (far left) with fellow physicians from the “Foreign Legion” of Sir Harold Gillies’ Plastic Surgery Service in London (1939)

for covering injured skin that enabled large areas to be covered using a small amount of healthy skin⁵: the checkerboard or chessboard graft, also called the postage-stamp graft.

Gabarró published a description of this new method first in *British Medical Journal*²³ in 1943 (*A new method of grafting*) and later (1944) in *Proceedings of the Royal Society of Medicine*²⁴, within an article titled *Discussion on modern methods of skin grafting*, where in addition to a detailed description of the method accompanied by numerous illustrations, he included new cases he had treated with photographs showing patients’ evolution. This method was based on the use of lamellar grafts cut into small squares from a large piece and placed with a small separation between them to cover a greater area of the skin’s surface while allowing the exudate produced to flow. This approach enabled large burnt or ulcerated surfaces to be covered using a minimum of skin, favouring autografts and avoiding excessive extraction²⁵.

in this work entitled; and Prof. O'Connor, Conway, and Kane, University College, Dublin, Dr. James McMurray and Dr. Robert Marshall, Belfast, for their interest, advice, and help.

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A NEW METHOD OF GRAFTING

BY
F. GABARRÓ

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 Plastic Surgeon in Charge at an Emergency Hospital

In order that the principles of the new method may be understood it will be useful first to give a short review of the usual types of skin graft. According to the thickness of the graft four types will be considered: (1) the thin Ollier-Thiersch graft, which has been described—not quite accurately—as only epidermic; (2) the intermediate or split graft, which contains the whole epidermis and a portion of the dermis; (3) a thicker graft of about three-quarters of the skin, which leaves just enough epithelial elements from the sweat and sebaceous glands for the epithelization of the donor area; (4) the whole-thickness skin, or Wolfe graft.

In the main, two considerations regulate the choice of graft: the thicker the graft the better the quality of the skin obtained; and the thinner the graft the easier it "takes." The area from which the graft is taken should epithelize in less than 15 days if the graft is thin. In thick grafts epithelization may be retarded, and subsequently some scar reaction may spoil the site for further use as a donor area. In the Wolfe graft there is a complete loss of skin, which must be replaced. It will be seen, therefore, that the donor area has its limitations. The kind of graft to be used depends, too, on the local condition of the area to be grafted and on the general condition of the patient, and is not an easy matter to decide upon. One of the chief problems arises when the area to be grafted is very big and the donor area is limited. When the donor area available is small, or the local and general condition of the patient is poor and none of the above-mentioned grafts is considered advisable, use is often made of small rounded grafts, of which there are two types: the thin or Reverdin graft, and the thick or deep graft devised by Davies and commonly called the "pinch" graft. Both are obtained by the same technique. The latter is the one generally adopted in England.

The Pinch Graft

It is necessary to review the pinch graft for the better understanding of this article. It is usually a small graft (3 to 5 mm. in diameter), rounded, deep, and containing all the layers of the skin. To obtain it a needle is used to pick up a cone of skin, which is cut at its base with a knife. The same needle carries the graft to the recipient area. Usually the pinch graft "takes" in raw areas in which no other graft will properly do so. This is why it is so useful. Moreover, it is easy to carry out. Many reasons are given to explain why the pinch graft takes so easily. In my opinion, the main reason is that the grafts are so placed that enough room is left between them to allow of free discharge, and nothing intervenes between the graft and the recipient area. This is an application of the

well-known principle of general surgery that no infected area will heal unless there is ample room for the discharge to escape.

From this consideration there arises a conclusion that is one of the main supports of the new method of grafting: any graft will take more easily, and in poorer raw areas, if there is enough room for discharge inside the whole area grafted. Certainly, then, pinch grafts have many advantages, yet they have several very important disadvantages.

Disadvantages of the Pinch Graft.—(a) The donor area of a pinch graft is practically always spoiled as a further donor area for other types of graft. Numerous small scars or keloids are very common. (b) A big donor area is necessary if the pinch grafts are placed very close together—sometimes as big as the area to be grafted. (c) It is necessary to employ a large number of them, which may prove to be a very long and tedious job. (d) Because, through the instruments, contact is established between donor and recipient areas—very often slightly infected—infection may develop in the donor area. (e) Usually the site covered by pinch grafts consists of the good skin of the original pinch grafts surrounded by an area of fairly good skin; the rest is more or less keloidal tissue, in many cases with all the disadvantages of scar tissue.

The Ideal Graft.—It seems to me that if the pinch grafts were placed so close together that the distance between them was less than the possible easy spread of the grafts (from 6 to 9 times the original size of the pinch graft), the likelihood of the formation of good skin and quick epithelization would be much greater. Only experience can confirm this. If I am correct in my assumption, therefore, the ideal graft for the type of case mentioned must conform to the following rules:

1. Plenty of room must be left between the grafts for possible discharge.
2. The donor area must not be spoiled, so that it could be used again and again.
3. The graft should take easily—as well as or better than any other graft.
4. The technique must be fairly rapid in use and the number of grafts unlimited.
5. Contact, direct or indirect, must be avoided between donor and recipient areas.
6. The space between the grafts must be less than the possible easy and early spread of the epithelium.

Technique of the New Method

A graft of the desired thickness and from one-sixth to one-ninth of the raw area to be co-erred is cut from the donor area. It is placed on stiff sticky paper (I have been using the greasy and sterile paper supplied with boxes of "tulle-gras") or any other material of similar qualities, and skin and paper are cut in strips as thin as convenient (Fig. 1). The strips are again placed on the same type of paper, at the distances desired,

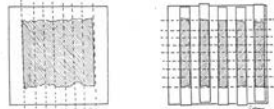


FIG. 1.—The graft, raw side up, is placed on sterile, stiff, sticky paper and cut into strips. FIG. 2.—The strips, placed on another piece of paper, are cut horizontally.

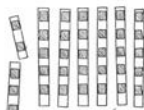


FIG. 3.—Small squares of graft on two thicknesses of paper (only one thickness shows here). The grafts, which retract somewhat, are ready to be placed in position, with the paper.

First page of the first article P. Gabarró published in 1943 in *British Medical Journal* on the new method soon to become known as "Gabarró chessboard graft"²³

(DEC. 16, 1944)

New Inventions

BOARD FOR CUTTING SKIN GRAFTS OF DEFINITE WIDTH

WHEN a skin-graft is being cut free-hand, a wooden board is usually employed to flatten the skin in front of the knife, so that the knife will have an even surface to work on. Kliner¹ devised a skin-stretching apparatus for this purpose, and Blair² used a suction-box. With the usual board the width of the graft cut depends on the width of the flat surface in front of the knife—it is not possible to cut a narrow graft from a broad thigh, and there is no other way of controlling the width of the graft than by choosing an appropriate donor area. The Blair suction-box permits definite control of the width



FIG. 1.—Stainless steel board.

of the graft, but it is necessary to have a different box for each width, and a good suction apparatus is not always available. In practice the wooden board is most used because of its simplicity, but with a board it is not easy to cut a skin-graft free-hand from such excellent donor areas as the abdomen, the chest or the back.

I have overcome these difficulties by devising a simple board made of stainless steel (fig. 1) to determine the width of surface for the knife to cut. It has four notches of different sizes—2, 2½, 3½ and 4½ in.—and when pressed down on the donor area produces a flattened salient the same width as the notch (fig. 2); the width of graft obtained is about half an inch less. It is necessary to hold the metal board more nearly perpendicular

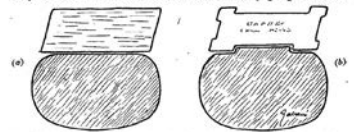


FIG. 2.—(a) Flat surface obtained with the ordinary wooden board applied to a limb. The width of the graft depends on width of donor area. (b) Surface obtained with the new board applied to same limb. There is a flattened salient of a definite width which is independent of width of donor area.

to the surface than the usual board, and to apply slightly more pressure, but this adjustment is simple in practice. This board has been employed, with satisfactory results, for over two years, using the Blair or Humby knife, or the old amputation knives (which I should recommend). With the Humby knife, which allows one to control the thickness of the graft cut, and this board, which controls its width, it has been possible to cut, free-hand, grafts of any width and thickness not only from the classical donor areas—the inner side of the arms and thighs—but also from the buttocks, chest, back and abdomen. The board is made to my design by Messrs. C. P. Thackeray Ltd., of London.

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3. See *Fomon's Surgery of Injury and Plastic Repair*, Baltimore, 1950, fig. 66, p. 134.

First publication about the plate that would be called the "Gabarró board" in *The Lancet*²⁹

Gabarró presented this new method at meeting of the Royal Society of Medicine held on 1 December 1943 (which would give rise to the publication in *Proceedings*²⁴), which was widely disseminated in *The Lancet*^{26,27}. This method enabled the lives of many burn patients to be saved in a period when other techniques were not available and tissue banks did not exist. It soon became known as “Gabarró checkerboard grafts” or “Gabarró postage-stamp grafts”²⁸.

In December 1944, Pere Gabarró published a study in *The Lancet*²⁹ that would give rise to another eponym: *Board for cutting skin grafts of definite width*. This article described a metal plate that enabled the graft width to be controlled exactly, a considerable improvement on the wooden boards used up until that point. Gabarró board is useful when taking a graft of not too extensive an area: it holds the skin taut, and it has indentations on each side of a rectangle with a differing graft width that makes cutting easier³.

The *Diccionari Enciclopèdic de Medicina*¹ includes another eponym, Gabarró dermatome, defined as a specific type of dermatome (an instrument for cutting lamellar skin segments, employed in graft surgery) that obtains very thin and small lamellae, with highly satisfactory results.



Pere Gabarró in the Pica d'Estats (Pyrenees, Spanish-French border)

As noted above, Pere Gabarró's name is immortalised not only in medical eponyms, but also in features of the Catalan mountains he knew so well: "via Gabarró" and "Punta de Gabarró".

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